



**UFCW Northern California & Drug Employers
Health and Welfare Trust Fund
LIFE & ACCIDENTAL DEATH CLAIM FORM**

EMPLOYEE INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Social Security #: _____

DECEASED INFORMATION (SELECT EMPLOYEE OR DEPENDENT AND COMPLETE THE RELEVANT SECTION)

Employee Deceased

Date of Death: _____ Date of Birth: _____
MM/DD/YYYY MM/DD/YYYY
Last Date Worked: _____ Name of Last Employer: _____
MM/DD/YYYY

Dependent Deceased

First Name: _____ Middle Initial: _____ Last Name: _____
Date of Death: _____ Date of Birth: _____
MM/DD/YYYY MM/DD/YYYY

Relation to Employee: Spouse *[Required Documentation: Copy of Marriage Certificate]*
 Domestic Partner *[Required Documentation: RDP Certificate]*
 Child *[Required Documentation: Copy of Birth Certificate]*
 Other: _____

CLAIMANT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Social Security #: _____ Date of Birth: _____ Phone #: _____
MM/DD/YYYY
Address: _____
STREET CITY STATE ZIP CODE

Under penalty of perjury, I hereby certify that the above information was correct upon the deceased's death.

X _____
CLAIMANT'S SIGNATURE MM/DD/YYYY

REQUIRED ATTACHMENTS FOR ALL CLAIMS:

CERTIFIED COPY OF THE DEATH CERTIFICATE

PLEASE COMPLETE AND RETURN TO: UFCW & EMPLOYERS TRUST, P.O. BOX 4100, CONCORD, CA 94524-4100